

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12882

CERTIFICATE OF DEATH

12870

Reg. Dist. No. 252

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ridge				c. LENGTH OF STAY IN 1b 2 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ridge	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last David Chester Dean				4. DATE OF DEATH Month Day Year December 19, 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 19, 1926	
9. AGE (In years last birthday) 30 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Day Labor		10b. KIND OF BUSINESS OR INDUSTRY Bricklayer	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME David Richard Dean		14. MOTHER'S MAIDEN NAME Myrtle Mae Copsey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs Chester Dean Ridge, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1/2 hour							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 12-14-56 to 12-19-56 , that I last saw the deceased alive on 12-14-56 and that death occurred at 6:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) California, Md. DATE SIGNED 12-19-56							
ACTUAL SIGNATURE Wm. H. Patrick M.D.				PHYSICIAN'S NAME (Type) William H. Patrick M.D. California, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/21/56		22c. NAME OF CEMETERY OR CREMATORY Joy Chapel		22d. LOCATION (City, town, or county) (State) Hollywood, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley ADDRESS Leonardtwn, Md.				24a. REC'D BY REGISTRAR 12/20/56		24b. REGISTRAR'S SIGNATURE Alan S. Houser	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

DEC 26 1956

RECEIVED

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12883

CERTIFICATE OF DEATH

Reg. Dist. No.

12871

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn		c. LENGTH OF STAY IN 1b 29 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital		d. STREET ADDRESS Chaptico	
3. NAME OF DECEASED (Type or print) First Lucy Middle Gray Last Gray		4. DATE OF DEATH Month December Day 9 Year 19 56	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1886
9. AGE (In years last birthday) yrs. 70		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maids		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-30-8342	
17. INFORMANT Miss Mary R. Fowler		Address Chaptico, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cachexia 164X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Mediastinal tumor prob DUE TO (c) Carcinoma		INTERVAL BETWEEN ONSET AND DEATH 2 mo 6 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1950 , to Dec 9 1956 , that I last saw the deceased alive on Dec 9 1956 , and that death occurred at St. Mary's , M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. J. Roy Guyther		M.D. Richardson DATE SIGNED Dec 12/9/56	
PHYSICIAN'S NAME (Type) Dr. J. Roy Guyther M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/11/56	
22c. NAME OF CEMETERY OR CREMATORY St. Joseph's		22d. LOCATION (City, town, or county) (State) Morganza, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley		ADDRESS Leonardtwn, Md.	
24a. REC'D BY REGISTRAR 12/12/56		24b. REGISTRAR'S SIGNATURE Glenn L. Hauser	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12872
282
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Marys MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY St. Marys			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt:235 Lexington Park, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) California			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS Rural			
3. NAME OF DECEASED (Type or print) First Adolph Middle --- Last Halvorsen				4. DATE OF DEATH Month 12/ Day 15 Year 1956			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/28/1889	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) porter				10b. KIND OF BUSINESS OR INDUSTRY cafeteria		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Andrew Halvorsen				14. MOTHER'S MAIDEN NAME Ellen Hansen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes				16. SOCIAL SECURITY NO. 33-07-6426		17. INFORMANT Mrs. Elizabeth Martinsen and, N.Y.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured cervical vertebra DUE TO (b) 819X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH Immed			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Automobile collision			
20c. TIME OF INJURY Month, Day, Year Hour a. m. Dec 15 19 56 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) Lexington Park St Marys Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE J. Roy Guyther				DATE SIGNED 12/15/56			
EXAMINER'S NAME (Type) J. Roy Guyther				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/20/56		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md.				24a. REC'D BY REGISTRAR 12/20/56			
				24b. REGISTRAR'S SIGNATURE Alan S. Hume			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
DEC 26 1956
BUREAU V. S

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12885

CERTIFICATE OF DEATH

Reg. Dist. No. 12873

1. PLACE OF DEATH o. COUNTY St. Mary's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY St. Mary's				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Patuxent River			c. LENGTH OF STAY IN 1b 48 minutes		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) USNAS, Patuxent River, X			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Station Hospital, USNAS, Patuxent River, Maryland				d. STREET ADDRESS 710C, MEMQ		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last HUTTON				4. DATE OF DEATH Month Day Year December 17, 19 56				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-17-56		9. AGE (In years lost birthday) yrs. Months Days Hours Min 48		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Patuxent River, Md.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME James HUTTON				14. MOTHER'S MAIDEN NAME Anne Wilhelmina Hauer				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address J. Hutton, USNAS, Patuxent River, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC-RESPIRATORY FAILURE 774X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) IMMATURITY DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 48 minutes 48 minutes						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 17 Dec , 19 56 , to 17 Dec , 19 56 , that I last saw the deceased alive on 17 Dec , 19 56 , and that death occurred at 9:31 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Station Hospital, USNAS, 12-18-56								
ACTUAL SIGNATURE Charles E. Look				M.D. Station Hospital, USNAS, 12-18-56				
PHYSICIAN'S NAME (Type) C. E. LOOK, LT MC USNR				Patuxent River, Maryland				
22b. DATE THEREOF 12-21-56		22c. NAME OF CEMETERY OR CREMATORY Holy Face Cem.		22d. LOCATION (City, town, or county) (State) Lexington Park, Md.				
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS				24a. REC'D BY REGISTRAR DATE 12-21-56		24b. REGISTRAR'S SIGNATURE P. J. Bean, M.D.		

2050332XVO

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. RACE White		5. BIRTH DATE 12-5-1928		6. BIRTH PLACE Jackson, Mississippi	
7. DECEASED DATE 4-4-1968		8. DECEASED TIME 10:00 AM		9. DECEASED PLACE FBI Office, Memphis, Tennessee	
10. DECEASED CAUSE Suicide		11. DECEASED MANNER Homicide		12. DECEASED DISEASE None	
13. DECEASED OCCASION None		14. DECEASED PLACE FBI Office, Memphis, Tennessee		15. DECEASED TIME 10:00 AM	
16. DECEASED PLACE FBI Office, Memphis, Tennessee		17. DECEASED TIME 10:00 AM		18. DECEASED DISEASE None	
19. DECEASED MANNER Homicide		20. DECEASED OCCASION None		21. DECEASED PLACE FBI Office, Memphis, Tennessee	
22. DECEASED TIME 10:00 AM		23. DECEASED DISEASE None		24. DECEASED MANNER Homicide	
25. DECEASED OCCASION None		26. DECEASED PLACE FBI Office, Memphis, Tennessee		27. DECEASED TIME 10:00 AM	
28. DECEASED DISEASE None		29. DECEASED MANNER Homicide		30. DECEASED OCCASION None	
31. DECEASED PLACE FBI Office, Memphis, Tennessee		32. DECEASED TIME 10:00 AM		33. DECEASED DISEASE None	
34. DECEASED MANNER Homicide		35. DECEASED OCCASION None		36. DECEASED PLACE FBI Office, Memphis, Tennessee	
37. DECEASED TIME 10:00 AM		38. DECEASED DISEASE None		39. DECEASED MANNER Homicide	
40. DECEASED OCCASION None		41. DECEASED PLACE FBI Office, Memphis, Tennessee		42. DECEASED TIME 10:00 AM	
43. DECEASED DISEASE None		44. DECEASED MANNER Homicide		45. DECEASED OCCASION None	
46. DECEASED PLACE FBI Office, Memphis, Tennessee		47. DECEASED TIME 10:00 AM		48. DECEASED DISEASE None	
49. DECEASED MANNER Homicide		50. DECEASED OCCASION None		51. DECEASED PLACE FBI Office, Memphis, Tennessee	
52. DECEASED TIME 10:00 AM		53. DECEASED DISEASE None		54. DECEASED MANNER Homicide	
55. DECEASED OCCASION None		56. DECEASED PLACE FBI Office, Memphis, Tennessee		57. DECEASED TIME 10:00 AM	
58. DECEASED DISEASE None		59. DECEASED MANNER Homicide		60. DECEASED OCCASION None	
61. DECEASED PLACE FBI Office, Memphis, Tennessee		62. DECEASED TIME 10:00 AM		63. DECEASED DISEASE None	
64. DECEASED MANNER Homicide		65. DECEASED OCCASION None		66. DECEASED PLACE FBI Office, Memphis, Tennessee	
67. DECEASED TIME 10:00 AM		68. DECEASED DISEASE None		69. DECEASED MANNER Homicide	
70. DECEASED OCCASION None		71. DECEASED PLACE FBI Office, Memphis, Tennessee		72. DECEASED TIME 10:00 AM	
73. DECEASED DISEASE None		74. DECEASED MANNER Homicide		75. DECEASED OCCASION None	
76. DECEASED PLACE FBI Office, Memphis, Tennessee		77. DECEASED TIME 10:00 AM		78. DECEASED DISEASE None	
79. DECEASED MANNER Homicide		80. DECEASED OCCASION None		81. DECEASED PLACE FBI Office, Memphis, Tennessee	
82. DECEASED TIME 10:00 AM		83. DECEASED DISEASE None		84. DECEASED MANNER Homicide	
85. DECEASED OCCASION None		86. DECEASED PLACE FBI Office, Memphis, Tennessee		87. DECEASED TIME 10:00 AM	
88. DECEASED DISEASE None		89. DECEASED MANNER Homicide		90. DECEASED OCCASION None	
91. DECEASED PLACE FBI Office, Memphis, Tennessee		92. DECEASED TIME 10:00 AM		93. DECEASED DISEASE None	
94. DECEASED MANNER Homicide		95. DECEASED OCCASION None		96. DECEASED PLACE FBI Office, Memphis, Tennessee	
97. DECEASED TIME 10:00 AM		98. DECEASED DISEASE None		99. DECEASED MANNER Homicide	
100. DECEASED OCCASION None		101. DECEASED PLACE FBI Office, Memphis, Tennessee		102. DECEASED TIME 10:00 AM	

BUREAU V. S.

JEC 26 1956

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VS. A15ME(S)
SM 9/55

STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Reg. Dist. No. 282									
1. PLACE OF DEATH a. COUNTY St Mary's MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St Mary's				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn			c. LENGTH OF STAY IN 1b 20 Min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Mary's Hospital					d. STREET ADDRESS				
3. NAME OF DECEASED (Type or print) First Middle Last Charles Jarboe					4. DATE OF DEATH Month Day Year December 6, 1956				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 8, 1874		9. AGE (In years, mo., days) 82 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Patent Office		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (State or foreign country) Maryland		IF UNDER 1 YEAR Months Days Hours Min. 1 28		IF UNDER 24 HRS.	
13. FATHER'S NAME James Henry Jarboe					14. MOTHER'S MAIDEN NAME Mary Rebecca Adams				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Miss Louise Jarboe Leonardtown, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Nicotine Poisoning 971.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Drank Insecticide						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Leonardtwn Md.		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>									
ACTUAL SIGNATURE Paul F. Guerin					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.					DATE SIGNED 12/6/56				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/8/56		22c. NAME OF CEMETERY OR CREMATORY St Paul's			22d. LOCATION (City, town, or county) (State) Leonardtwn, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Md.					24a. REC'D BY REGISTRAR 12/7/56		24b. REGISTRAR'S SIGNATURE Gerald A. Hauser		

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

DEC 10 1956

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12875

CERTIFICATE OF DEATH

12887

Reg. Dist. No. 281

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>St. Marys</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>St. Marys</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>California</u>		LENGTH OF STAY (in this place) <u>life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>California</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>rural</u>				STREET ADDRESS (If rural give location) <u>ryral</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Samuel</u> <u>----</u> <u>Kane</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>12/</u> <u>28/</u> <u>19 56</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>5/15/1872</u>	9. AGE last birthday <u>84</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farm tenant</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Hillary Kane</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT & ADDRESS <u>Iseabelle Barnes- California, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331x IMMEDIATE CAUSE (A) ANTECEDENT CAUSE(S) DUE TO (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)				Cerebral atherosclerosis and hemorrhage Generalized arteriosclerosis Interval between onset and death 1 week 6 years			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May</u> , 19 <u>50</u> , to <u>Dec</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec 26</u> , 19 <u>56</u> , and that death occurred <u>11:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>P.J. Bean</u>		M.D. <u>Great Mills, Md.</u>		DATE SIGNED <u>12/30/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/31/56</u>		NAME OF CEMETERY OR CREMATORY <u>Holy Face Cemetery</u>		LOCATION (City, town, or county) (State) <u>Great Mills, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>12/30/56</u>		REGISTRAR'S SIGNATURE <u>M. S. Robinson</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>P.B. Robinson - Leonardtown, Md.</u>			

CERTIFICATE OF DEATH

FILE NO.

NAME OF DECEASED

DATE OF DEATH

AGE

SEX

CAUSE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

RELIGION

DATE OF MARRIAGE

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

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BUREAU V. 2

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

128782
Reg. Dist. No.

12888

1. PLACE OF DEATH a. COUNTY <u>St. Marys</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Abell</u> c. LENGTH OF STAY IN 1b <u>life</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rural</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Marys</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Abell</u> d. STREET ADDRESS <u>Rural</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																											
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Joseph</u> Last <u>Lawrence</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>6,</u> Year <u>19 56</u>																											
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 18, 1919</u>		9. AGE (In years last birthday) <u>37</u> yrs. <table border="1" style="display: inline-table; width: 100%;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.														
IF UNDER 1 YEAR		IF UNDER 24 HRS.																													
Months	Days	Hours	Min.																												
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck driver</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>milk dairy</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>usa</u>																							
13. FATHER'S NAME <u>Arthur B. Lawrence Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Florence Morris</u>																											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>				16. SOCIAL SECURITY NO. <u>WW 2 216-14-6150</u>		17. INFORMANT <u>Corinne L. Lawrence- Abell, Md.</u>																									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <table border="1" style="width: 100%;"> <tr> <td colspan="4"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Electric shock</u> </td> <td colspan="2"> INTERVAL BETWEEN ONSET AND DEATH <u>immed</u> </td> </tr> <tr> <td colspan="4"> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. </td> <td colspan="2"></td> </tr> <tr> <td colspan="4"> DUE TO (b) </td> <td colspan="2"></td> </tr> <tr> <td colspan="4"> DUE TO (c) </td> <td colspan="2"></td> </tr> </table>								PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Electric shock</u>				INTERVAL BETWEEN ONSET AND DEATH <u>immed</u>		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						DUE TO (b)						DUE TO (c)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Electric shock</u>				INTERVAL BETWEEN ONSET AND DEATH <u>immed</u>																											
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																															
DUE TO (b)																															
DUE TO (c)																															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																															
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Contacted high voltage electric line</u>																											
20c. TIME OF INJURY Month, Day, Year <u>4:50 p.m. DEC 6 19 56</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Abell, St Marys Co Md</u>																							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .																															
ACTUAL SIGNATURE <u>J. Roy Guyther</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED																							
EXAMINER'S NAME (Type) <u>J. Roy Guyther</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>																							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/10/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart</u>		22d. LOCATION (City, town, or county) <u>Bushwood, Md.</u>		(State)																							
23. FUNERAL DIRECTOR'S SIGNATURE <u>P.B. Robinson - Leonardtown, Md.</u>				ADDRESS		24a. REC'D BY REGISTRAR <u>DATE 12/11/56</u>		24b. REGISTRAR'S SIGNATURE <u>Gerald A. Hausen</u>																							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
JAMES EARL RAY		35		M		W		4-4-68	
PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		LOCALITY	
BALTIMORE, MD		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE		BALTIMORE, MD	
OCCUPATION		EDUCATION		RELIGION		MARITAL STATUS		SINGLE	
CLERK		HIGH SCHOOL		METHODIST		MARRIED		MARRIED	
PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS DRUGS		PREVIOUS ALCOHOL	
NONE		NONE		NONE		NONE		NONE	
SIGNATURE OF EXAMINER		DATE OF EXAMINATION		PLACE OF EXAMINATION		SIGNATURE OF WITNESS		DATE OF WITNESS	
JAMES EARL RAY		4-4-68		BALTIMORE, MD		JAMES EARL RAY		4-4-68	

RECEIVED
DEC 12 1956
BUREAU V. 3

TO HOSPITAL OF ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12889

CERTIFICATE OF DEATH

Reg. Dist. No.

12877
282

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn				c. LENGTH OF STAY IN 1b 2Hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Compton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Baby Middle Girl Last Mattingly				4. DATE OF DEATH Month December Day 21 Year 1956			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 21, 1956	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Jennings Mattingly				14. MOTHER'S MAIDEN NAME Hilda Marie Watts			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intra cranial hemorrhage 760.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Premia Lurida - 7 mos DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Absence of external genitalia, unperforate anus							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 12/21 , 19 56 , to 12/21 , 19 56 , that I last saw the deceased alive on 12/21/56 , 19 56 , and that death occurred at 330 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Roy Guyther				M.D. Mechanicsville 12/22/56			
PHYSICIAN'S NAME (Type) J. Roy Guyther M.D.				Mechanicsville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		12/24/56		St. Aloysius		Leonardtwn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley				ADDRESS Leonardtwn, Md.		24a. REC'D BY REGISTRAR DATE 12/27/56	
				24b. REGISTRAR'S SIGNATURE Alan S. Henry			

2078380XV2

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		MALE		35		JAN 5 1921		MOBILE		ALABAMA		UNITED STATES		UNITED STATES	
RACE		COLOR		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		SPECIAL OCCUPATION		MILITARY SERVICE	
WHITE		WHITE		METHODIST		MARRIED		HIGH SCHOOL		CLOCK MAKER		CLOCK MAKER		ARMY	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		PERMANENT HOME		TEMPORARY HOME		LAST RESIDENCE		LAST ADDRESS	
APR 4 1968		MEMPHIS, TENNESSEE		HEART DISEASE		SUICIDE		MEMPHIS, TENNESSEE		MEMPHIS, TENNESSEE		MEMPHIS, TENNESSEE		MEMPHIS, TENNESSEE	
TIME OF DEATH		DATE OF BURIAL		PLACE OF BURIAL		CEREMONY		FUNERAL HOME		COST		CITY		STATE	
10:00 PM		APR 6 1968		MEMPHIS, TENNESSEE		METHODIST		JAMES EARL RAY FUNERAL HOME		\$100.00		MEMPHIS, TENNESSEE		MEMPHIS, TENNESSEE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF JUDGE		SIGNATURE OF CLERK		SIGNATURE OF DEPUTY CLERK		SIGNATURE OF ASSISTANT CLERK	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

BUREAU V. 2

DEC 28 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12878

12890

CERTIFICATE OF DEATH

Reg. Dist. No.

282

1. PLACE OF DEATH o. COUNTY St. Mary's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Lexington Park				c. LENGTH OF STAY IN 1b 3 yrs				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Lexington Park			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Joseph Middle Archie Last Moore				4. DATE OF DEATH Month December Day 26 Year 19 56							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1899		9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saw Mill				10b. KIND OF BUSINESS OR INDUSTRY Laboref		11. BIRTHPLACE (State or foreign country) North Carolina				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 426-14-1382		17. INFORMANT Ella Moore				Address Lexington Park, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) myocarditis DUE TO (c) Hypertensive Cardio Vascular Disease								INTERVAL BETWEEN ONSET AND DEATH 30 min. 1 year 10 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Sept 1 , 19 56 , to Dec 26 , 19 56 , that I last saw the deceased alive on Dec 15 , 19 56 , and that death occurred at 5:30 M, from the causes and on the date stated above.											
ACTUAL SIGNATURE Wm. H. Patrick				M.D. Lexington Park Md.				DATE SIGNED 12-26-56			
PHYSICIAN'S NAME (Type) William H. Patrick M.D.				ADDRESS California, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/28/56		22c. NAME OF CEMETERY OR CREMATORY Ebeneza		22d. LOCATION (City, town, or county) (State) Grange Mills, Maryland					
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley						ADDRESS Leonardtwn, Md.		24a. REC'D BY REGISTRAR 12/27/56		24b. REGISTRAR'S SIGNATURE Alan A. Hower	

18 JARVIS AND STATE DEPARTMENT OF HEALTH—BALTIMORE

RECEIVED

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12879
282

Reg. Dist. No.

12891

1. PLACE OF DEATH a. COUNTY <u>St. Marys</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Marys</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Abell</u>		c. LENGTH OF STAY IN 1b <u>life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Abell</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rural</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>James LeRoy Morris</u>				4. DATE OF DEATH Month Day Year <u>Dec. 6, 1956</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 11, 1917</u>			
9. AGE (In years last birthday) <u>39 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Watherman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sea Food</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>usa</u>				13. FATHER'S NAME <u>William S. Morris</u>			
14. MOTHER'S MAIDEN NAME <u>Ethel Crismond</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <input checked="" type="checkbox"/> (If yes, give war or dates of service) <u>WW 2</u>			
16. SOCIAL SECURITY NO. <u>579-01-3664</u>				17. INFORMANT <u>Charles S. Morris- Abell, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Electric shock</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>914.0</u> (c), stating the underlying cause lost. DUE TO <u>immed</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>Interval between onset and death</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Contacted high voltage electric line</u>					
20c. TIME OF INJURY Month, Day, Year <u>4:50 p. m. DEC 6 1956</u>		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>			
20f. (City or town) <u>Abell</u>		(County) <u>St Marys Co Md</u>		(State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>J Roy Guyther</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>J. Roy Guyther</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>12/10/56</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart</u>				22d. LOCATION (City, town, or county) (State) <u>Bushwood, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>P.B. Robinson - Lepnardtwn, Md.</u>				24a. REC'D BY REGISTRAR <u>12/11/56</u>			
ADDRESS				24b. REGISTRAR'S SIGNATURE <u>Glenn D. Hansen</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

DEC 12 1956

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

STATE DEPARTMENT OF HEALTH—BALTIMORE, 18														
Item 20 Film 208 12-28-56 ams														
12892														
CERTIFICATE OF DEATH														
Reg. Dist. No. 12880 282														
1. PLACE OF DEATH o. COUNTY St. Mary's MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY St. Mary's									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn					c. LENGTH OF STAY IN 1b 13 days					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mechanicsville				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital					d. STREET ADDRESS					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Maria Turner First Middle Last					4. DATE OF DEATH Month December Day 10 Year 19 56									
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 7, 1859		9. AGE (In years last birthday) 97 yrs.		IF UNDER 1 YEAR Months 11 Days 3 Hours Min. 				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Wilson Turner					14. MOTHER'S MAIDEN NAME Martha Turner									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. None		17. INFORMANT Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia 903.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Fracture of hip DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell getting out of bed									
20c. TIME OF INJURY Month, Day, Year Hour 6:30 p.m. Nov 24 1956					20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Mechanicsville		(County) St. Marys		(State) Md.	
21. I certify that I attended the deceased from Jan 1956 to Dec 10 1956 , that I last saw the deceased alive on Dec 10 1956 and that death occurred at 2:30 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mechanicsville Md DATE SIGNED Dec 12 1956														
ACTUAL SIGNATURE J. Roy Guyther M.D.					PHYSICIAN'S NAME (Type) J. Roy Guyther M.D. Mechanicsville, Maryland									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 12-13-56		22c. NAME OF CEMETERY OR CREMATORY All Faith			22d. LOCATION (City, town, or county) New Market,			(State) Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Md.					ADDRESS		24a. REC'D BY REGISTRAR DATE 12/2/56		24b. REGISTRAR'S SIGNATURE Dean D. Hauser					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12893

CERTIFICATE OF DEATH

12881

Reg. Dist. No. 282

1. PLACE OF DEATH o. COUNTY St Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurry Rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Baby Middle Girl Last Somerville		4. DATE OF DEATH Month December Day 3 Year 19 56	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 2, 1956
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months 1 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Joseph Somerville		14. MOTHER'S MAIDEN NAME Mary Josephine Young	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT William Joseph Somerville		Address Hurry, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial Hemorrhage 760.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 17 hrs DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that 12/2 attended the deceased from 12/2 , 19 56 , to 12/3 , 19 56 , that I last saw the deceased alive on 12/3 , 19 56 , and that death occurred at 8 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mechanicville, Md. DATE SIGNED 12/7/1956 ACTUAL SIGNATURE Roy Guyton M.D. Leonardtwn, Md. PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/5/56	
22c. NAME OF CEMETERY OR CREMATORY St. Aloysius		22d. LOCATION (City, town, or county) (State) Leonardtwn, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley		ADDRESS Leonardtwn, Md.	
24a. REC'D BY REGISTRAR 12/7/1956		24b. REGISTRAR'S SIGNATURE Clarence D. Hauser	

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12882

CERTIFICATE OF DEATH

12894

Reg. Dist. No. 281

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY St. Marys		MARYLAND		STATE Maryland		COUNTY St. Marys	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Leonardtown		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lexington Park,			
HOSPITAL OR INSTITUTION OR STREET ADDRESS St. Marys Hospital				STREET ADDRESS Rural			
3. NAME OF DECEASED (Type or Print) Margaret Jane Stevens				4. DATE OF DEATH (Month) (Day) (Year) 12/ 29 / 19 56			
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH 5/30/1873	9. AGE last birthday 83 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Shade				14. MOTHER'S MAIDEN NAME Massie Arndt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) no		16. SOCIAL SECURITY NO. -----		17. INFORMANT & ADDRESS Robert A. Stevens- Lexington Park Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) 331X Cerebral hemorrhage				INTERVAL BETWEEN ONSET AND DEATH 3 days			
ANTECEDENT CAUSE(S) DUE TO (B) Generalized arteriosclerosis				10 years			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Arthritis deformans				10 years			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Dec 28, 1956 , to Dec 28, 1956 , that I last saw the deceased alive on Dec 28, 1956 , and that death occurred at 11:15 A.M. from the causes and on the date stated above.							
SIGNATURE P. J. Bean				ADDRESS (Street, city, town, state) Great Mills, Md.			
DATE 12/31/56				DATE SIGNED 12/30/56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 12/31/56		NAME OF CEMETERY OR CREMATORY Ebenezer Cemetery		LOCATION (City, town, or county) California, Md.	
24. REC'D BY REGISTRAR DATE 12/30/56		REGISTRAR'S SIGNATURE P.B. Robinson		25. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md.			

CERTIFICATE OF DEATH

1957

Jan. 2, 1957

Medical Record No. 123456789

Place of Death

MARYLAND

St. Mary's Hospital

Age

Sex

Color

Marital Status

Occupation

Education

Religion

Usual Residence

Place of Birth

Date of Birth

Place of Birth

Date of Birth

Place of Birth

Date of Birth

Place of Birth

Date of Birth

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TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12883

CERTIFICATE OF DEATH

12895

Reg. Dist. No. 282

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>St. Marys</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>St. Marys</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Leonardtwn</u>				TOWN <u>Mechanicsville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>St. Marys Hospital</u>				STREET ADDRESS (If rural give location) <u>Rural</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Sarah Cecelia Tennyson</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>12/ 28 / 1956</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>widowed</u>	8. DATE OF BIRTH <u>8/21/1877</u>	9. AGE last birthday <u>79</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Gates</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Burch</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service) <u>-----</u>				16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT & ADDRESS <u>J. Burch Tennyson- Mechanicsville, Md.</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
241X IMMEDIATE CAUSE (A) <u>Cardiac decompensation</u>						<u>1 mo</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic pulmonary emphysema</u>						<u>5 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>and cor pulmonale</u>							
				<u>Bronchial asthma</u>		<u>20 yrs</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Arthritis, rheumatoid</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY straal, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan. 1948</u> , to <u>Dec. 28, 1956</u> , that I last saw the deceased alive on <u>Dec. 27, 1956</u> and that death occurred at <u>9:50 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>J. Roy Guyther</u>				ADDRESS (Street, city, town, state) <u>Mechanicsville, Md.</u>			
DATE <u>12/28/56</u>				DATE SIGNED <u>12/28/56</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>12/31/56</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		LOCATION (City, town, or county) <u>Washington, D.C.</u>	
24. REC'D BY REGISTRAR <u>1/2/57</u>		REGISTRAR'S SIGNATURE <u>Donald O. Hauser</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>P.B. Robinson</u>		ADDRESS <u>Leonardtwn, Md.</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12896
CERTIFICATE OF DEATH

12884
Reg. Dist. No. 212

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn		c. LENGTH OF STAY IN 1b 12 hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hollywood	
4. DATE OF DEATH Month December Day 26 Year 19 56		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Melvin First Leroy Middle Weeks Last		9. AGE (In years last birthday) 48 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 9 Days 13 Hours Min. 	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 13, 1908
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boat repair		10b. KIND OF BUSINESS OR INDUSTRY Ship Yard	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Pirley Weeks		14. MOTHER'S MAIDEN NAME Virginia Combs	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-14-2122	
17. INFORMANT Mrs Melvin L. Weeks		Address Hollywood, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 24 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1950 to Dec 26, 1956 , that I last saw the deceased alive on Dec 25, 1956 , and that death occurred at 7A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mechanicsville, Md DATE SIGNED 12/2/56 ACTUAL SIGNATURE Joy Gayther M.D. Mechanicsville, Md PHYSICIAN'S NAME (Type) J. Roy Gayther M.D. Mechanicsville, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/29/56	
22c. NAME OF CEMETERY OR CREMATORY Joy Chapel		22d. LOCATION (City, town, or county) (State) Hollywood, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley		ADDRESS Leonardtwn, Md.	
24a. REC'D BY REGISTRAR DATE 12/3/56		24b. REGISTRAR'S SIGNATURE Alan N. Hannon	

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

12885

Reg. Dist. No. 282

1. PLACE OF DEATH COUNTY <u>St. Marys</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Mechanicsville</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rural</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>St. Marys</u> CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Mechanicsville</u> STREET ADDRESS (If rural give location) <u>Rural</u>	
3. NAME OF DECEASED (Type or Print) <u>James Wilbert Winters</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>12 / 22 / 19 56</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>single</u>	8. DATE OF BIRTH <u>6 / 13 / 56</u>
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>James W. Platter</u>		14. MOTHER'S MAIDEN NAME <u>Gladis M. Winters</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>-----</u>	
17. INFORMANT & ADDRESS <u>Gladis M. Winters - Mechanicsville Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 527.2 IMMEDIATE CAUSE (A) <u>Respiratory infection-acute, fulminating, with probable septicemia</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>-----</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>-----</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 d.</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>-----</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>12/22</u> , 19 <u>56</u> , to <u>12/22</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12/22</u> , 19 <u>56</u> , and that death occurred at <u>10A</u> M., from the causes and on the date stated above.			
SIGNATURE <u>J. Roy Guyther</u>		ADDRESS (Street, city, town, state) <u>Mechanicsville, Md.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/24/56</u>	
24. REC'D BY REGISTRAR <u>Alan W. Hauser</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>P.B. Robinson - Leonardtown, Md.</u>	

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CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF BURIAL SOCIETY

16. SIGNATURE OF CHURCH

17. SIGNATURE OF CEMETERY

18. SIGNATURE OF FUNERAL HOME

19. SIGNATURE OF CARRIER

20. SIGNATURE OF OTHER

21. SIGNATURE OF OTHER

22. SIGNATURE OF OTHER

23. SIGNATURE OF OTHER

24. SIGNATURE OF OTHER

25. SIGNATURE OF OTHER

26. SIGNATURE OF OTHER

27. SIGNATURE OF OTHER

28. SIGNATURE OF OTHER

29. SIGNATURE OF OTHER

30. SIGNATURE OF OTHER

BUREAU V. S.

DEC 25 1956

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